STATE OF NEW YORK COURT OF CLAIMS

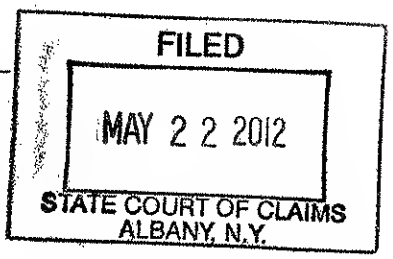
SERGIO BLACK,

Claimant, DECISION

-v-

STATE OF NEW YORK, Claim No. 115567

Defendant.



BEFORE: HON. DIANE L. FITZPATRICK
Judge of the Court of Claims

APPEARANCES: For Claimant:
FRANZBLAU DRATCH, P.C.
By: Brian M. Dratch, Esquire
Stephen Dratch, Esquire

For Defendant:
ERIC T. SCHNEIDERMAN
Attorney General of the State of New York
By: Michael R. O'Neill, Esquire
Patricia M. Bordonaro, Esquire
Assistant Attorneys General

Claimant, an inmate at Five Points Correctional Facility, brings this claim for the alleged medical malpractice and negligence of the State in their evaluation and medical care of his condition which he alleges caused him to suffer spinal cord compression and paraplegia. He alleges the State failed to timely diagnose, refer, and treat his spinal stenosis, and prescribed inappropriate medications all of which deviated from the standard of care and caused his permanent injuries.

Claimant was born, April 5, 1971. He graduated from high school, served in the Marine Corps and was deployed to Iraq. When he returned, he had a full-time job in a debt collection agency and worked part-time jobs as security and a bouncer for a night club. Prior to his conviction and current incarceration, he had also served a local sentence for a drug possession conviction. Claimant has six children. His son, Thomas, age 13, died November 11, 2006, while Claimant was incarcerated at Five Points. During his incarceration, Claimant also married his wife, Antoinette, on February 15, 2006; they have no children together.

Claimant's back problems were first documented in his Ambulatory Health Record (AHR) on October 27, 2005, when he complained about back pain and indicated he had "twisted" his back.

Claimant arrived at Five Points Correctional Facility in December 2005, and participated in both educational programs and an over-35 basketball league. He was also a regular weightlifter, doing 400 repetitions of 125 lbs., and lifting by "dead lift" 325 lbs. At Five Points, Claimant first complained of back pain or "back strain" on May 25, 2006 on the right side of his back related to weightlifting. He was given analgesic balm, exercises, naproxen, and Tylenol. On June 5, 2006, he collided with another player while playing basketball and felt like he couldn't move for 30-60 seconds. He didn't fall but stopped playing the game. The next day he went to sick call and his AHR from that visit reflect he complained about a "pull" down his back. The nurse scheduled another appointment for him. He was seen on July 6, 2006, and complained about a "recurring back injury" from May 25, 2006; he was scheduled for another appointment

with a medical provider.[1] On July 20, 2006, Claimant again was seen at the infirmary for recurring back pain, worsened by prolonged sitting and side numbness. The doctor ordered x-rays which were taken on July 28, 2006, and were normal except for minimal spurring at T-11, 12.

On November 8, 2006, as documented in the AHR, Claimant testified that during a basketball game his head snapped back and he could not move. He was carried to the infirmary from the gym. He complained of numbness and tingling in his left leg. He was examined and could move his head and neck, bend and pull his knees up to his chest and had positive reflexes in his feet. He was placed on Medical Hold,[2] indicating he couldn't work or participate in any recreation activities except cards and television until November 13, 2006. He stayed in the infirmary overnight. The next morning he complained of tingling and swelling in his left leg. The nursing notes indicate his leg was warm but not swollen.

Later that morning, Claimant was seen by Dr. Daniel Weinstock, a physician employed by the facility, Board Certified in Internal Medicine. Dr. Weinstock had worked with the Department of Corrections and Community Supervision (DOCCS) at Five Points since September 2004, and full-time since 2005. In 2006, he accepted the position of Facility Health Services Director (FHSD), treating inmate-patients and supervising other medical providers. Prior to his work at Five Points, he worked at Geneva General Hospital from 1977 to 2006 in the Department of Medicine and then the Emergency Medical Department.

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[1] A medical provider was one of the two staff doctors, a physician's assistant or a nurse practitioner. The registered and licensed practical nurses were not considered medical providers.

[2] See Exhibit Q.

Dr. Weinstock noted in his entry from his evaluation of Claimant on November 9, 2006, that: "In basketball last night a player came down from jump, hit his head on vertex. . . and hyper-extended his neck. Complains of transient numbness in all extremities, but now only mild numbness left leg. Also lateral left ankle sprain, no loss of conscious[ness]. Physical examination, moves all extremities, neck, full range of motion, non-tender. . ."[3] Dr. Weinstock diagnosed a "stinger-burn" neurapraxia[4] and a left ankle sprain.

Claimant continued to complain his legs did not feel right so he stayed in the infirmary again that night. Dr. Weinstock also issued a cane for him to use according to the AHR.[5]

The next day, Dr. Weinstock noted Claimant was still numb in his left toes and unsteady on his feet. He prescribed Motrin and crutches until November 17[6] and a follow-up on November 13. Claimant was discharged from the infirmary. Claimant was issued an ace wrap until November 16.[7] Claimant recalled not being able to raise his left leg, being in pain and described his balance was off. He felt his condition worsening.

On November 13, Claimant continued to complain of left leg and arm numbness and weakness. Dr. Weinstock felt that these symptoms had continued for too long for a transient neurapraxia, so he ordered an MRI (magnetic resonance imaging) of Claimant's cervical spine to

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[3] Trial Transcript, March 15, 2011, p. 25.

[4] Mild focal nerve lesion that produces clinical deficits; localized loss of conduction along a nerve without axon degeneration, caused by focal lesion, usually demyelinating and followed by a complete recovery (*Stedman's Medical Dictionary,* p. 1198 [26th ed. 1995]).

[5] The medical permits reflect, however, that on November 10, 2006, Claimant was issued crutches. The crutches were returned and a cane issued on November 15, 2006 (*see* Exhibits T and Y).

[6] Exhibit T.

[7] Exhibit S.

rule out herniated nucleus pulposus.[8] The MRI had to be performed outside of the facility and Claimant signed a contract[9] agreeing to undergo diagnostic imaging and providing the necessary information.[10] The appointment was scheduled and the MRI performed on November 15, 2006 at Arnot-Ogden Memorial Hospital.

On November 15, 2006, Claimant was issued a cane to assist with his mobility. On November 17, 2006, Claimant attended his son, Thomas's funeral. He recalled needing the cane to get from the facility van to the church. He was not allowed the use of a cane at the funeral, and he needed assistance from family to get back to the van.

On November 20, 2006, Claimant saw Dr. Weinstock early in the day and although his left ankle had healed, he still complained of numbness and weakness in his left extremities. His Medical Hold was extended until November 23, with the additional restriction that he be fed in his cell rather than having to go to the mess hall for meals.[11] Claimant was still using the cane. The MRI results had not yet been received.

Later in the morning on November 20, 2006, Dr. Weinstock received the MRI results. He wrote in the AHR: "significant cervical spinal stenosis[12] and myelomalacia.[13] The recent trauma probably exacerbated the underlying chronic disease and has resulted in [left] side weakness,

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[8] Herniated disc.

[9] Exhibit V.

[10] Trial Transcript, March 14, 2011, p. 111.

[11] Exhibit BB.

[12] A stricture of any canal (*Stedman's Medical Dictionary,* [26th ed. 1995] p. 1673).

[13] Softening of the spinal cord (*Stedman's Medical Dictionary,* [26th ed. 1995] p. 1166).

numbness."[14] According to Dr. Weinstock, there were no acute abnormalities seen on the MRI such as herniated nucleus pulposus, about which Dr. Weinstock was concerned. The doctor then noted he would see Claimant soon to arrange for a neurosurgery evaluation. Dr. Weinstock sent a note to Claimant alerting him that the MRI results had arrived, and they would review them together soon.[15]

On November 27, Claimant went to sick call to obtain the MRI results and to complain about the pain. The note reflects he wanted to see the warden so that he could get his MRI results. He made a further request on December 4. Claimant testified he wanted the results because he felt his condition was getting worse and testified that he informed the medical staff of this; however, that is not reflected in the AHR.

On December 7, 2006, Dr. Weinstock met with Claimant to discuss the MRI results and explained to Claimant that his spine was pressing on the nerves in his spinal column. Dr. Weinstock checked Claimant's reflexes and asked about his pain. Claimant said he told the doctor that he was in pain and was so dizzy upon standing that he sometimes felt he would black out. Claimant signed the required contract to obtain a neurological consultation at that time. Dr. Weinstock made the referral and prescribed Neurontin, which Claimant believed was a muscle relaxer.

Dr. Weinstock testified that he did not contact Claimant on November 20, when he first read the MRI results, because he did not see anything of an emergent nature that would require him to have Claimant return that day so something could be done immediately. The findings, he

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[14] Exhibit Z; *see* Trial Transcript, March 15, 2011, p. 49.

[15] Exhibit 2.

said, showed a degenerative disc disease of desiccated[16] discs at several levels, posterior osteophytes[17] and myelomalacia which takes months or years to develop. He was reassured by the report since there was no acute process occurring. His Medical Hold was continued until January 1, 2007.

On December 18, Claimant was in his cell and the nurse came to give him his Neurontin at approximately 5:30 a.m. Claimant fell going from his bunk to the door and could not get up. He said he could not move at all and could hear the nurse calling to the correction officer to open the cell door. He was taken to the infirmary on a backboard and Dr. Gregoire was notified. The AHR note of 5:40 a.m. written at the infirmary indicates Claimant had back and neck pain. Both arms and hands were flaccid but responsive to painful stimuli. The note at 8:30 a.m., reads Claimant was dizzy and fell backwards onto his neck.[18] Claimant could not grip his hands. He was still in the infirmary at 10:30 a.m., on a Solu-Medrol drip and surgery had been scheduled at SUNY Upstate for the next day to relieve the spinal stenosis.

The medical records from the hospital[19] state that on December 18, Claimant could not move or feel his legs and had minimal movement in his arms. He was diagnosed with acute spinal cord compression syndrome. The next day he had surgery. The operation was described

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[16] Desiccation means drying out of the discs per Dr. Weinstock.

[17] A bony outgrowth or protuberance (*Stedman's Medical Dictionary,* [26th ed. 1995] p. 1270).

[18] Claimant testified he doesn't recall being dizzy before he fell but the Court finds the more contemporaneous records most persuasive.

[19] Exhibit MM.

as "C3-T1 posterior decompressive laminectomies and C3-T4 posterior spinal fusion with pedicle screws, lateral mass screws and rods..."[20]

Claimant was discharged on January 3, 2007, with numerous prescribed medications and an Aspen cervical collar. The discharge summary[21] indicated Claimant still could not move his legs although he "did withdraw to noxious stimulus." He had no motor strength of his wrists but could feel light touch to his arms.

At the time he fell, Claimant said he was terrified, he couldn't move. He didn't know if he would recover feeling or movement in the future.

At the time of trial, Claimant was still in custody at Walsh Medical Facility. He is confined to a bed or wheelchair and has only limited use of his right arm and hand but cannot adjust the hospital bed or manipulate the wheelchair. His left arm has minimal movement. Claimant described his daily routine. He wakes up about 6:00 a.m., and three days per week the nurse on duty gives him a suppository to regulate his bowel movements. The nurse then helps him sit up, and he reads until they take his vital signs and bring him breakfast. On his right hand is a device to which various utensils can be attached. One attachment allows him to turn pages so he can read. His food is cut into bite-size pieces and placed on a special plate. Claimant is then positioned upright and the plate is properly placed to allow him to feed himself. After eating, he can also brush his teeth when a toothbrush is attached to the device by the staff. The staff then either bathes him in the bed or takes him to the shower. It takes more than one person to help him in the shower. Most of the day, Claimant spends studying. He can watch television

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[20] Exhibit PP.

[21] Exhibit QQ.

or listen to music. In the evenings, he goes to religious services. His physical therapy and occupational therapy have stopped as there is nothing more they can do for him.

Claimant is currently on medication for anxiety and depression and meets with a psychiatrist regularly. Before his fall, he had never been treated for any mental health issue.

Claimant can type for short periods of time until his arm tires. He has painful, involuntary spasms and takes anti-seizure medication. He cannot experience an erection and is catheterized to urinate. He has suffered from urinary tract infections, occasionally, and bedsores fairly often. He gets low back pain and headaches. The depression makes him antisocial at times and he has had suicidal thoughts.

Antoinette Black, Claimant's wife, testified that she became concerned about Claimant in late June 2006. She indicated that he complained to her about pain, weakness, and numbness after the basketball incident in November. When visiting him, she felt a change in his grip when they held hands; his hand felt "floppy." She noted his need for assistance to walk at his son's funeral on November 17, 2006. When she saw him on November 20, 2006, she felt his condition was worsening, and after her visit on November 27, she was so concerned that she called the facility to speak with the doctor. She did not speak with him, and the next time she saw Claimant he was in the hospital.

In November and December 2006, DOCCS had written protocols[22] for referring patients for testing, evaluation, and treatment both inside and outside of the facility, and Dr. Weinstock testified he was familiar with them. Inside the facility, the inmate would initially be seen at sick

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[22] Exhibit 33.

call by a nurse who would, if necessary, make an appointment with a medical provider. The outside referral must be made by a qualified referrer and approved by Dr. Weinstock as FHSD. Dr. Weinstock acknowledged that timely referrals and treatment were important, and a referral can be made if it is "in the best interest of the patient."[23] The DOCCS has defined urgency levels for referrals which are used both inside and outside the facility.[24] An "emergent" appointment requires the patient to be seen within 24 hours. This is a term of action for the facility and is not equivalent to a medical emergency requiring immediate attention. "Urgent" requires the patient to be seen within five days. "Soon" means within 14 days. A "routine" appointment requires the patient to be seen within 30 days and "assigned" means that the appointment can be more than 30 days in the future. Dr. Weinstock testified that this means not only that the appointment has to be made within this time frame but that the patient has to actually be seen.[25]

Before an outside referral is made, the inmate has to sign a contract agreeing to keep the appointment and, if he fails to do so after signing the contract, he can be subject to disciplinary action. An inmate has five days to rescind his consent to the referral appointment in the contract.

Dr. Weinstock made the neurosurgical consultation referral the same day that he saw Claimant to review the MRI results, December 7, 2006. The referral is entered into the DOCCS computer system. As part of the referral, the provider would outline the medical situation, the reason the referral was needed, identify the provider and the urgency level. Kelly Ripa, who worked in the Medical Records Department at Five Points and arranged medical appointments

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[23] Trial Transcript, March 14, 2011, p. 111.

[24] Trial Transcript, March 14, 2011, p. 129.

[25] Trial Transcript, March 14, 2011, pp.129-130.

outside of the facility, identified the computer printout referral for Claimant's neurological consultation.[26] It reads, "Hyperextension of neck in basketball on November 8, 2006 with persisting L arm and L leg weakness and numbness since. MRI shows osteophytes, severe spinal stenosis and myelomalacia C3-4. Mild central disc bulge C4-5 and C5-6 with mild stenosis of canal at C5-6. In view of the post-traumatic onset of symptoms and the myelomalacia (possibly post-trauma) request a soon NES evaluation."[27] The MRI report was not included with the transmission.

After a referral is made it is reviewed by an independent medical review service, in this case A.P.S., before the appointment is scheduled. Here, Dr. Weinstock's referral was approved the same day at 11:57 a.m. Once the appointment is approved by this independent review service, the referral is scheduled with an appropriate approved medical facility through a health service scheduler in Albany. Denise Jones, one of the health service schedulers in Albany, testified and indicated that she notes the urgency status of the referral in order to arrange a timely appointment. Ms. Jones testified that the only medical facility at which she could arrange neurological consultations for inmates at Five Points was the State University of New York, Upstate Medical University Hospital (hereinafter University Hospital). At University Hospital she could not schedule an appointment directly, the neurological clinic arranged the appointment after the referral gets faxed to the clinic and reviewed.

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[26] Exhibits 31 and FF.

[27] Exhibit FF.

On December 7, 2006, a staff member in Ms. Jones' office faxed the referral for Claimant to the University Hospital Upstate Neurosurgical Clinic.[28] It was received that day.[29] On December 11, 2006, Ms. Jones called the Upstate Neurosurgical Clinic to check on Claimant's appointment. She was advised that before an appointment could be scheduled, the MRI report was needed. On December 13, 2006, Ms. Jones e-mailed Ms. Ripa at Five Points requesting the MRI report be sent to the Upstate Neurosurgical Clinic. On December 15, 2006, the report was faxed, and Ms. Ripa notified Ms. Jones the same day that it had been successfully transmitted.

George Running, worked at University Hospital's surgical speciality call center receiving referrals by telephone or fax for various clinics and scheduling appointments. Mr. Running testified that DOCCS schedulers should know that test results, such as an MRI report, need to accompany a referral. Doris Buschbacher, a supervising nurse in the University Hospital Surgical Speciality Outpatient Clinics, indicated it was required or at least recommended to send all pertinent patient information along with the referral including, x-rays, imaging reports, etc. It was Mr. Running's job to advise once a referral was received if something was missing. On December 13, 2006, his "notes"[30] indicate he contacted Ms. Jones' coworker requesting Claimant's MRI report, as noted on the December 12, 2006, Neurosurgical Clinic nurse's notation on the referral fax cover sheet.[31]

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[28] Exhibits 30, LL and VV.

[29] Exhibit VV.

[30] Exhibit XX.

[31] Exhibits 30, LL and VV, notation of Nurse Cindy Franciscelli.

Once the Upstate Neurosurgical Clinic has all of the necessary information, it reviews referrals every Wednesday morning. Inmate patients are seen on the alternate Wednesdays; other non-inmate patients are seen on the other alternate Wednesdays. A nurse from the clinic goes to the call center throughout each week to review the referrals received and note if something is missing or more information is needed so that it may be obtained before the review. The clinic codes the referrals based upon the urgency level identified at the facility, either 1-4 or A-D. On the cover sheet of Claimant's referral there is a notation with a circled "B," Dr. Hodge's signature, and the date of 12/20/06. This means that Dr. Hodge reviewed Claimant's information on December 20, 2006, and designated Claimant's priority status a "B." Mr. Running testified that he was unaware of the meaning of the DOCCS urgency levels and thought that "soon" meant the next available appointment. In the clinic a "B" designation meant an appointment within a month or two. Given the alternate Wednesday schedule for seeing inmate patients, Mr. Running indicated that even an "A" designation would mean that the patient may not be seen for two weeks. With an "A" or "B" designation, the doctor could decide to overbook to accommodate the need since, typically, they only see between 10 and 12 patients each alternating Wednesday. DOCCS can also call to try to get a scheduled appointment moved to a sooner time which would require the approval of the attending neurosurgeon. Such a request would be documented.

According to Nurse Doris Buschbacher, if all of the documentation had been in Claimant's file as of December 7, 2006, the date of the referral, it would have been reviewed on December 13. She also indicated that DOCCS would not have been given the clinic's urgency levels.

On December 21, Ms. Jones received a telephone call indicating that Claimant's case had been reviewed on December 20, and an appointment would be forthcoming. This was too late, since three days before Claimant suffered acute spinal cord compression and was admitted to University Hospital.

Claimant called an expert witness, Dr. Lawrence W. Shields, a Board Certified Neurologist.[32] Dr. Shields began his career in the military as a general medical officer at the Federal Correctional Institution Hospital in California. Thereafter, he became the Chief Medical Officer at the Federal Correctional Institution Hospital in Connecticut. He then did a neurology residency at Brookdale Hospital in New York and has had various positions in neurology at several hospitals. He currently practices neurology with two other neurologists at Community Hospital, Long Beach, New York.

Defendant argues that in this case Dr. Shields' opinion should be given no weight because his expertise is that of a neurologist, and the standard of care for a neurologist is different than that of a general practitioner or internist. The Court rejects Defendant's argument. Although Dr. Shields is a neurologist, he worked as a general practitioner at the beginning of his career and, in fact, worked as a prison doctor for a couple of years before becoming a neurologist. He also testified that he trained family practice and internal medicine doctors on how to do competent neurological medical examinations.[33] Unlike the situation where you have a general practice physician testifying about the standard of care for a specialty area, or a specialist testifying to the

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[32] The Trial Transcript at certain points during Dr. Shield's testimony is unclear so the Court has relied upon its trial notes and the recording of the trial (*see* for example January 11, 2011, p. 47).

[33] Trial Transcript, January 11, 2011, p. 38.

standard for an unrelated specialty area, here, Dr. Shields' knowledge of the standard of care applicable to Dr. Weinstock in the prison setting is apparent from his credentials (*see Hoagland v Kamp,* 155 AD2d 148, 150 [3d Dept 1990]; *but see Ozugowski v City of New York,* 90 AD3d 875 [2d Dept 2011]).

In reaching his opinion, Dr. Shields reviewed all of Claimant's medical records and examined Claimant. Dr. Shields began by describing the anatomy of the spinal column and explaining how wear and tear and age cause the development of bone spurs or osteophytes. The overgrowth of the facet joints lessen the space for the spinal cord which moves every time our body moves. The worst effect of the limiting of space for the spinal cord in the spinal column is loss of blood supply. The loss of blood supply results in neuro-tissue damage that becomes irreversible after two or three hours. Thus, it is critical to prevent this emergency condition which has little chance of reversal.

Dr. Shields found that starting from June 6, 2006, Claimant had complaints of total body numbness which was evidence of a spinal cord problem. Dr. Shields felt an MRI should have been ordered at this time. There is, however, no indication of this numbness in the AHR and, thus, no indication that Claimant told the medical staff at the facility about body numbness at that time. Body numbness was a complaint in the July 20, 2006 entry, and Dr. Shields felt that a neurological consultation should have been obtained. An x-ray of the lumbosacral spine is not the appropriate test for total body numbness.

The next important date is November 9, 2006. On this date Dr. Shields noted that only a partial neurological examination of Claimant was performed, and the failure to perform a full examination or to refer Claimant to someone who could do one was a deviation from the

standard of care. Dr. Shields also opines that Dr. Weinstock's failure to appreciate Claimant's history of complaints that could have spinal cord involvement was a deviation from the standard of care. Dr. Shields described Dr. Weinstock's suspicion of neuropraxia as usually involving nerves, although, it can involve the spinal cord and reflects a functional disturbance without structural damage. The patient with neurapraxia recovers quickly within a day or so. In this case, Claimant's condition worsened. The MRI, which Dr. Shields indicated should have been performed even earlier, showed the spinal cord compression due to spondylopathic changes to the cervical spine. This condition can worsen on its own over time, but it is important that a patient with this condition be watched and protected against further injury. Dr. Shields noted that the MRI report[34] indicates there was already a decreased signal intensity in the intervertebral disc spaces consistent with desiccation and degenerative signal disease. This means that the discs are drying out. The MRI report also noted a large bone spur at C3 to C4, with marked narrowing of the spinal canal and increased signal intensity in the spinal cord posterior to the C3 and C4 disc space. This reflects abnormality or loss of tissue already at that level in the spinal cord. At this level the spinal cord normally starts to widen, but in Claimant it is markedly narrowed. Myelomalacia was also shown at that level, which means softening or, in this case, a drop of neurons, that is replacement of normal spinal tissue with fibrous tissue with some fluid.

Two conditions are exposed by the MRI,[35] a degenerative condition affecting the boney spine and its connections and also the secondary affect on the spinal cord. In the MRI, the spinal cord is compressed about 75 percent. Dr. Shields indicated a C3-4 compression with

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[34] Exhibit 8.

[35] Dr. Shields indicated that this is shown in the schematic portions of Exhibit 15.

myelomalacia can affect control of voluntary movement of the arms and legs, limiting the ability to successfully ward off a fall. It also makes the lower part of the cord vulnerable.

It was Dr. Shields' opinion that Claimant should have had surgery immediately after the MRI results were obtained because it was critical to decompress the spinal cord. Instead, the surgery was performed after the spinal cord was irreparably injured. If the surgery had been performed shortly after November 15, 2006, the progression of the lesion would have stopped, and Claimant would have had over a 50 percent[36] chance of significant improvement; although, he may have suffered some weakness and clumsiness in his legs and may have had bladder issues. He would not have been a quadriplegic. The failure to send this patient for surgery after receiving these MRI results was a deviation from the standard of care, according to Dr. Shields. Although the decision to perform surgery is not solely dependent on the results of an MRI, clinical information is also important. Here, where the MRI was coupled with continuing signs of progression, surgery was necessary.

Dr. Shields reviewed Dr. Weinstock's December 7, 2006, health record notations which reflect that the MRI results were reviewed with Claimant, and Claimant continued to have left side weakness. No examination of Claimant is noted, which should have been done to assess his condition. Neurontin was prescribed. That drug was originally an anticonvulsant agent, but is now also used to treat patients with chronic pain. Dr. Shields opined that this prescription was inappropriate and contraindicated because its side effects include dizziness, ataxia,[37] and

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[36] The Transcript reads 15% (*see* January 11, 2011, Transcript, p. 55), but the Court's contemporaneous notes and the trial recording reflect that the testimony was actually 50 percent (*see* January 11, 2011, Transcript, p. 66).

[37] Defined as "[a]n inability to coordinate muscle activity during voluntary movement, so that smooth movements occur" (*Stedman's Medical Dictionary* [26th ed. 1995] p. 161).

somnolence. Ataxia is the most disturbing side effect because it involves uncoordination and clumsiness, even in the absence of weakness. All three of these side effects tend to promote falling. Given Claimant's existing complaints of difficulty walking and weakness on the left side of his body, Dr. Shields felt this prescription only increased the likelihood Claimant would fall and suffer further injury. Prescribing this medication was, according to Dr. Shields, a deviation from the standard of care. Dr. Shields also opined that the medication would not work for the purpose it was prescribed - to reduce Claimant's pain.

In Dr. Shields' opinion, Claimant's condition continued to deteriorate from the time of his basketball injury on November 8, until his fall on December 18. He went from playing basketball to holding onto walls to walk. Dr. Shields opined that Claimant's use of Neurontin coupled with the continued weakening of his left side and difficulty walking, all contributed to his fall. Dr. Shields found it significant that Claimant requested a wheelchair because it reflects his difficulty ambulating and his left side weakness. Dr. Weinstock denied this request.[38] Claimant's medical records do not document Claimant's deteriorating condition. Yet, Claimant's neurological condition was not evaluated because no neurological examination was performed.

The December 19, 2006 surgery performed on Claimant, after his fall, removed the boney elements intruding on his spinal cord and stabilized his spine. Metal plates and screws were

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[38] Exhibit II.

implantcd from C3 to T4.[39] Laminectomies[40] were performed from C3 to T1[41] to prevent additional injury, which could result in Claimant bcing respirator depcndent.

Dr. Shields' post-injury examination of Claimant revealed that he was alert and oriented. He had almost full ncck movement but no voluntary leg movement other than a slight ability to bring his thighs together and apart. He also had no functional use of his hands. He does have some movemcnt of his right arm which he can use to feed himself and brush his teeth with attached utensils and toothbrush. Food must be cut appropriately in order for him to be able to feed himself. He also can move the ring finger on his right hand, which is unusual, and he can use a computer. Claimant also has somc joint position sense which indicates, according to Dr. Shields, that some fibrous tracts remain intact and accounts for Claimant's complaints of pain, despite an overall loss of feeling from his mid-chest down. Thus, when Dr. Shields picked up Claimant's right leg Claimant could tell, although he had no joint position sense in his left leg. In his arms, on the right side, hc maintained joint position but could not discern feeling or localize pain from T3 down, and on his left sidc it was from T7 down.[42] Claimant also has clasp-knife rigidity in his limbs. This mcans if his limbs are moved there is some resistance initially which then recedes.

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[39] Exhibit 15, lower right panel.

[40] The surgical removal of the posterior arch of a vertebra (*Merriam-Webster's Medical Desk Dictionary*, p. 425 [1996]).

[41] Exhibit 15, lower center panel.

[42] Dr. Shields indicated that this is shown in the schematic portions of Exhibit 15.

During this examination, Claimant also had spinal myoclonus, which is a jumping or jerking of his limbs. These are reflex movements, because some of the spinal cord remained intact. Claimant has no control over these movements. These movements were observed during Claimant's videotaped testimony. Claimant also uses a urinary catheter and diaper. His sexual functioning is lost.

Dr. Shields indicated that Claimant's condition will not improve. Instead, it will worsen over time through the normal aging process which causes a loss of reserved neurons in our neuro-system. Claimant already has less neurons in reserve. Claimant may also need additional surgery since the plates and screws in his spine can loosen over time.

Legal Discussion

The State has the duty to provide inmates in its correctional facilities with reasonable and adequate medical care (*Rivers v State of New York,* 159 AD2d 788 [3d Dept 1990], *lv denied,* 76 NY2d 701 [1990]). Physicians have the duty to possess the necessary knowledge and skill, possessed by average practitioners in their field, to use reasonable care and diligence in applying that knowledge and skill and to exercise their best judgment in treating and caring for their patients (*Pike v Honsinger,* 155 NY 201, 209). To establish liability for medical malpractice, Claimant has the burden to show by a preponderance of the credible evidence that Dr. Weinstock's care and treatment deviated from accepted standards of care and the alleged deviation proximately caused his injuries (*Mullally v State of New York,* 289 AD2d 308 [2d Dept 2001]).

After reviewing all of the evidence, the Court finds that Claimant has met his burden, and has established that Defendant's care of Claimant fell below acceptable standards of practice.

Defendant did not present any opposing expert medical testimony other than the testimony of Dr. Weinstock.

In reaching its conclusion, the Court does not accept Dr. Shields' position that the State should have considered a spinal cord injury as early as May, 2006. Despite some claims of lower back pain in early 2006, Claimant's first claim of numbness was July 20, 2006, and Claimant was promptly referred for an x-ray. Claimant's complaints were associated with basketball, and although he thereafter had some numbness in June and July, he continued to play basketball. Claimant also had several other visits to the infirmary during this time where no back complaints were noted. Thus, the Court does not find that Defendant's failure to consider a spinal cord injury at that time is a deviation from the standard of care given Claimant's continued activities and intermittent complaints. Dr. Shields agreed that if Claimant's description of his back pain and numbness was not provided to Defendant, the failure to consider a possible spinal cord injury at that time would not be a deviation from the standard of care. The situation is different, however, in November, 2006.

Claimant visited the infirmary on November 8, 2006, with complaints of numbness, weakness, and tingling in his legs after a basketball injury. He also complained of weakness in his arm. These symptoms continued at Claimant's follow-up visit on November 13, 2006. Dr. Weinstock appropriately ordered an MRI, which was timely done two days later. Claimant again returned to the infirmary on November 20, with the same complaints relying on a cane to ambulate. Dr. Weinstock directed that Claimant be fed in his cell, obviously recognizing the difficulty Claimant was having getting around.

Dr. Weinstock received the MRI results later the same day. Dr. Weinstock viewed the MRI report which, from his perspective, reflected a chronic degenerative condition, no acute process requiring immediate intervention. Yet, as Dr. Shields testified, this position fails to take into account Claimant's clinical picture. Prior to November 8, 2006, Claimant was playing basketball and active. Following that date, Claimant had great difficulty moving around. In reviewing Claimant's file, earlier complaints of back pain and numbness should have been factored into the context of the acute exacerbation. There is no indication from the medical records or Dr. Weinstock's testimony that this was done. Claimant, obviously, was concerned about his condition as he repeatedly sought to obtain the MRI results on November 27, and again on December 4. Claimant was in pain and had diminishing mobility. His AHR reflects he complained of pain and was using the cane. He sought a wheelchair on December 14, and again complained of pain and weakness. Despite this, Dr. Weinstock did not re-check Claimant's condition to sec if it had worsened and denied the wheelchair. Although a degenerative condition, which develops over time, may have warranted Dr. Weinstock's less than urgent approach to Claimant's condition in the absence of changing symptoms; here, Claimant's condition had significantly deteriorated in a short span of time, and he had increasing difficulty ambulating. Moreover, when Dr. Weinstock did finally meet with Claimant on December 7, 2006, he prescribed a drug with side effects that can cause clumsiness and uncoordination in a man already unsteady on his feet. Although Defendant tried to frame Dr. Weinstock's evaluation and treatment of Claimant as an exercise of his medical judgment, Claimant's presenting symptoms, risk of further damage to the spinal cord with a fall, and increasing the risk of Claimant falling, the Court does not find this was merely an error of medical judgment but rather

a deviation from the standard of care. There was no evidence Dr. Weinstock weighed alternative courses of care and treatment to arrive at what he determined was the best course of treatment. He read the MRI report, considered Claimant's condition a degenerative process and put his case on the back burner. His failure to re-evaluate Claimant on December 7 to assess any changes to his condition underscores the lack of reasonable care.

The delays between the date Dr. Weinstock received the MRI report and Claimant being scheduled to be seen at the Neurosurgical Clinic at University Hospital are solely attributable to Defendant's failure to recognize the urgency and risks of Claimant's condition and a failure of prompt and efficient internal procedures for which Claimant should not suffer the consequences. Claimant was confined to the custody of the State, he could not seek a second opinion or pursue other treatment options. The State controlled his provision of care and treatment. Under these circumstances, the State's failure to recognize the risks of potentially debilitating permanent injury as the result of Claimant's condition was particularly grievous.

Accordingly, the Court finds Defendant is 100 percent responsible for the Claimant's injuries as a result of the failure to promptly refer Claimant for a neurological consultation evaluation and treatment from November 20, 2006.

DAMAGES

As a result of Claimant's fall on December 18, 2006, he underwent spinal decompressive surgery on December 19, 2006. This surgery involved removal of the boney elements that were creating pressure on the spine. The surgery also involved a spinal stabilization procedure, which means he had metal implanted in his boney spine to stabilize it from C3 to T4.

Claimant has permanently lost voluntary mobility of his legs, except for some minor ability to bring his thighs together and apart. He is incontinent, uses a urinary condom catheter, and he has a suppository routine to facilitate bowel movements. He has to wear a diaper. He has complete loss of sexual function.

Claimant does have some residual joint position sense. His right arm has almost no sensation except for "C5 dermatome," which includes the front of the shoulder and limited into his bicep. In his left arm, he had sensation throughout the arm despite significant paralysis. He no longer has any functional use of his hands although he can move the fourth finger, or ring finger on his right hand horizontally and has limited movement of the thumb on his left hand. He can do some of his simple grooming, such as brushing his teeth with a special attachment, and he can feed himself with hook utensils if the food is properly cut. He can also operate a computer, again, with special attachments. He can bend or flex his elbows, with his left side being stronger than his right but cannot straighten his elbows.

Despite an almost complete loss of feeling from the nipple line of his chest down, he has some touching sense. This reflects, according to Dr. Shields, an incomplete spinal cord lesion, which explains why he still experiences some spontaneous pain. From T7 down on his left side and T3 on his right side, he has loss of sensation to touch, pinpricks, and temperature. On his left side, he had some perception to touch, but a complete loss of ability to discriminate what type of touch it is. Claimant also has spinal myoclonus which are involuntary striking movements of

parts of the body; "jumping and jerking limbs."[43] He also has some "clasp knife rigidity" which means that when you try to move his extremities there is some passive resistance.

Claimant also suffers chronic neck and shoulder pain. He is susceptible to bedsores, which occur on occasion. Claimant's cognitive functioning is in tact, and he does read and watch television.

It was Dr. Shields' opinion that over time his condition would get worse because as his neurological system ages he will, as part of the natural aging process, lose functioning neurons. Additionally, the metal implants in his spine can, over time, loosen and need replacement so depending on how long Claimant lives, he may need surgery to replace the metal plates.

Dr. Joseph Carfi, a physiatrist, specializing in physical medicine and rehabilitation prepared a Life Care Plan for Claimant after reviewing his history and records and interviewing and examining Claimant. Claimant is currently incarcerated and his care is and will be provided through DOCCS until his release on April 6, 2013. The Life Care Plan sets forth the medical and life care needs of Claimant for the balance of his life once he is released from prison in 2013.

Dr. Carfi noted from examining Claimant that he is totally dependent on others to provide his daily care other than some limited grooming and feeding ability. He also noted the constant spontaneous spasms in Claimant's legs. These are apparent from Claimant's video deposition.

Based upon Claimant's functioning and sensory level, Dr. Carfi diagnosed Claimant with "sensory incomplete C-5 quadriplegic with neurogenic bowel and bladder."[44] Dr. Carfi opined and the Court finds that Claimant's condition is permanent, and he will remain dependent upon

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[43] Trial Transcript, January 11, 2011, page 71.

[44] Trial Transcript, January 12, 2011, page 53.

others for his care for the balance of his life. Dr. Carfi opined Claimant's life will be lessened by 15 percent because as a quadriplegic he is prone to various medical complications such as respiratory conditions and infections.

The Life Care Plan is divided into categories: Medical Care; Medication; Lab Work; Medical Supplies and Equipment; Home Equipment Adaptations and Transportation; Therapies; and Home/Facility Care. Each item in each category has the time frame the item or service is needed, and/or the frequency, the cost per visit, or the base cost, and the annualized cost. His annualized cost for medical care and treatment is $31,259.59; for equipment and supplies is $16,664.80, with a one-time cost for home renovations of $37,600; therapies, $6,595.16; and annualized costs for home care services of $181,069.20.

One component of Dr. Carfi's Life Care Plan is the need for ongoing psychological care and treatment. Dr. David P. Schiebel, a physician, Board Certified in Psychiatry and Neurology testified to Claimant's mental health condition. The trauma caused by going from an active, athletic adult to a quadriplegic has left Claimant suffering from Post Traumatic Stress Syndrome. This condition is unlikely to change, and he will need ongoing care and treatment.

Claimant is entitled to reasonable compensation for his injuries and care that is appropriate for his physical and mental condition. Typically, the Court has before it two plans purporting to meet the medical and life needs of the Claimant. Although the Court here has only the Life Care Plan presented by Dr. Carfi, in carefully reviewing the plan, the Court finds, for the most part, it is realistic and tailored to meet Claimant's future needs given his limitations.

There is only one component of Dr. Carfi's Plan that the Court finds is not supported by the record. The Court is not bound to accept in its entirety expert testimony that it finds

incredible, although uncontradicted (*Ares v State of New York,* 176 AD2d 203 [1st Dept 1991] *affd* 80 NY2d 959 [1992]). In the Life Care Plan, Dr. Carfi has accounted for physical and occupational therapy each once a week for the balance of life. Yet, Claimant was receiving both therapies in prison after he became a quadriplegic but both were discontinued because there were no further gains being made. Since physical therapy focuses upon the lower body, and Dr. Carfi explains its needs as another set of skilled eyes watching him, the Court finds this is not an appropriate addition to the Life Care Plan. The life time occupational service, based upon Dr. Carfi's testimony, seems duplicative of the rehabilitation specialist who will also be monitoring for new functional technology available to assist Claimant. There was no proof that occupational therapy is necessary to allow Claimant to obtain functional use of his hands and upper body. Rather, it is presented solely as a means to assist Claimant in learning how to use new equipment. The Court does foresee this periodic need for occupational therapy to assist Claimant in his ability to use new equipment. The Court, however, finds it incredible that this will require weekly sessions for the rest of Claimant's life. Accordingly, the Court will reduce the cost of this therapy with the awareness that at times, such as when he is first released from custody, weekly occupational therapy may be necessary to facilitate Claimant's adjustment.

Finally, Dr. Carfi provided a wide range for estimated annual hospital care. The Court will use $16,857.50, which is the difference between the two levels, as a reasonable means of assessing the cost of Claimant's likely need for some period of hospitalization each year.

To determine the future cost of providing Claimant with the medical care, supplies, and assistance, the parties presented expert testimony. Erwin Schoenblum testified for Claimant and

Dr. Lawrence Spizman testificd for the defense as to the applicable growth rates to be applied to each component of the Lifc Carc Plan.

Mr. Schoenblum tcstified regarding the growth ratcs attributable to Dr. Carfi's Lifc Care Plan and Claimant's life expectancy. He has an Electrical Engineering Degree and an MBA but is not an economist; although, over the past 30 years, he has conductcd many forensic and cconomic evaluations. Dr. Lawrence Spizman is a forensic economist with a Ph.D. Dr. Spizman specializes in evaluating damages in wrongful death, personal injury, and labor cases. He has published in the field of forensic economics and teaches economics at a local college.

The State objected to Mr. Schoenblum's testimony because he did not havc an economics degree. He was allowed to testify as his qualifications go to the weight and not the admissibility of his testimony in this case (*Baity v General Elec. Co.* 86 AD3d 948, 950 [4th Dcpt 2011]). After evaluating the two experts' education and background, the Court has given grcater weight to Dr. Spizman's opinions and determinations.

Thc Court finds Claimant's life expectancy is to age 71.57 years, which includes the 15 percent reduction of his life expectancy as described by Dr. Carfi. Claimant's relcase date from prison is April 6, 2013, at which time the Life Care Plan will commence. Dr. Spizman detcrmined that the Claimant's life expectancy from his release date is 29.83 years. He also used January and June for the datcs Claimant would have appointments two times per year. Therefore, in 2013 he will only have one visit for certain specialists he will see twice per year or three times per year if the visits are quartcrly. There is also slight adjustments for the last year, 2042, to account for the .83 years.

Using Dr. Spizman's growth figures and correcting an error in his Home Health Aide calculations for 2013, pointed out on cross-examination, the Court finds the total cost of Claimant's future medical and life care needs is $12,207,898. There is no award for past expenses as Claimant was in the custody of the State.

The evidence also supports an award for Claimant's past and future pain and suffering. This is the portion of any damage award the Court finds most difficult to assess as many Courts have noted an injured party's pain and suffering does not lend itself to precise quantifications. It is necessary to review other cases to determine what has been considered reasonable compensation with similar injuries and circumstances (*Karney v Arnot-Ogden Mem. Hosp.* 251 AD2d 780, 782 [3d Dept 1998] *lv dismissed,* 92 NY2d 942 [1998]).

Based on the Court's review of similar cases, Claimant is awarded $1 million for past pain and suffering and $2.5 million for future pain and suffering, based on the Court's review, (*see Barnhard v Cybex Intl., Inc.* 89 AD3d 1554 [4th Dept 2011], broken neek from 600 lb. weight machine falling on her rendering her a quadriplegic, $3 million past pain and suffering, $9 million future; *Reed v City of New York,* 304 AD2d 1 [1st Dept 2003], $2.5 million past and $2.5 million future pain and suffering; *Auer v State of New York,* 289 AD2d 626 [3d Dept 2001], 18 year old quadriplegic, traumatic brain injury, spasticity, increased from $750,000 award of future pain and suffering to $1.5 million; *Rappold v Snorac, Inc.* 289 AD2d 1044 [4th Dept 2001], 41 year life expectancy, severe brain injury impaired mental and physical functioning $1 million past pain and suffering and $6 million future; *Santiago v New York City Health and Hosps. Corp.,* 278 AD2d 220 [2d Dept 2000], past pain and suffering $900,000, future $1.5 million; *Brown v City of New York,* 275 AD2d 726 [2d Dept 2000], quadriplegic and pentaplegic awarded

reduced sum of $1 million for past pain and suffering and $3 million for future; *Dupont v State of New York,* 19 Misc 3d 1144 [A] 2008 NY Slip Op 51160 [u] [Ct Cl 2008], placental abruption caused asphyxia, cerebral palsy, mental retardation and seizure disorder, past pain and suffering $1.2 million, and $1.5 million future; *Coniker v State of New York,* Ct Cl, Scuccimarra, J., signed Dec. 23, 2002, Cl. No. 86901, [UID #2002-030-085], 23-year-old quadriplegic suffering pain, muscle spasms, $1 million past and $2.5 million for future pain and suffering).

To recapitulate the Court's damage award:

Past Pain and Suffering -		$1,000,000.00
Future Pain and Suffering -		$2,500,000.00
Medical & Hospital Care -	$2,284,120.00	
Medications -	$ 247,199.00	
Lab Work	$ 234,745.00	
Medical Supplies	$ 256,218.00	
Home Equipment/Transportation	$ 286,719.00	
Occupational Therapy	$ 93,984.00	
Home Care	$8,804,913.00	
Total	$12,207,898.00	
Total Damage Award		$15,707,898.00

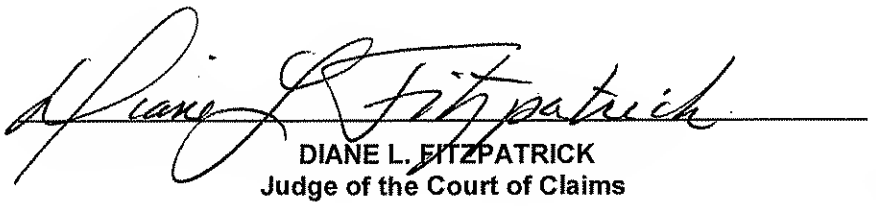
To the extent Claimant paid a filing fee, pursuant to Court of Claims Act § 11-a (2), he is entitled to reimbursement.

Since this award of future damages exceeds $500,000, a structured judgment is required (CPLR 5031). Let Judgment be held in abeyance pending a hearing pursuant to CPLR Article

50-A. The Court encourages the parties to reach a stipulation as to the attorney fee calculation, the discount rate to be applied to formulate a structured settlement of their own. In the event the parties cannot reach a settlement, each party should submit a proposed judgment within sixty (60) days of the date this Decision is filed with the Clerk of the Court. A hearing will thereafter be scheduled.

All motions not previously decided are now DENIED.

Syracuse, New York
March 30, 2012



DIANE L. FITZPATRICK
Judge of the Court of Claims